State Of Georgia Employee Benefit Plan Council

Your Group Long Term Care Insurance Plan

Policy No. 513565.001

Underwritten by Unum Life Insurance Company of America

11-2007

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Summary of Benefits. The Summary of Benefits is a part of the Select Group Insurance Trust sitused in Maine. Fleet Bank of Maine is the Trustee. The Summary of Benefits is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Group Identification Number: 513565

Caution: If you completed an Application for Long Term Care Insurance which included evidence of insurability, the issuance of this long term care insurance certificate was based upon your responses to the questions on your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM has the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

- Insured persons are entitled to examine a copy of the Summary of Benefits during regular office hours at the Sponsoring Organization's place of business.

- Insured persons also are entitled to examine a copy of the Master Policy by contacting UNUM directly.

- **You have a 30 day right to examine this certificate.**

  If, after examining this certificate, you are not satisfied for any reason, you may withdraw your enrollment in this plan by returning this certificate within 30 days of its delivery to you. The certificate, together with a written request for such withdrawal, must be sent to:

  - **if you are an active employee,** your Agency or the Sponsoring Organization's Plan Administrator,

  - **if you are a family member,** UNUM, PO Box 9744, Portland, Maine 04104-9868.

  Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned to you after receipt of your withdrawal.

- Throughout this certificate:

  - "you" or "your" means an active employee who is eligible for UNUM benefits.

    Also, "you", "your" or "family member" means:

    - the spouse of an active employee (you must be legally married to your spouse),

    - the natural, adoptive or step-parents of an active employee, or

    - the natural, adoptive or step-parents of a spouse of an active employee.

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- UNUM means UNUM Life Insurance Company of America,
- The terms "we", "our" and "us" refer to UNUM Life Insurance Company of America, and
- Sponsoring Organization means:

THE EMPLOYEE BENEFIT PLAN COUNCIL ON BEHALF OF THE STATE OF GEORGIA MERIT SYSTEM AND DEPARTMENTS

President

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SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS

Eligibility and participation	You may participate in the plan if you are an eligible employee of the Sponsoring Organization. Your family members are also eligible for the plan. Family members include your: • spouse (you must be legally married to your spouse), • natural, adoptive or step-parents, or • spouse's natural, adoptive or step-parents. Temporary or seasonal employees are excluded.

BASE COVERAGE

- **Daily Benefit Maximum ***

Residence	Plan A	Plan B	Plan C
Long Term Care Facility	$75	$100	$125
Assisted Living Facility	$45	$60	$75
Home or another similar place			
- Total Home Care	$45	$60	$75
Return of Premium (as defined)	Yes	Yes	Yes

AVAILABLE OPTIONS

• **Inflation Protection Option**	Yes	Yes	Yes
• **Nonforfeiture Coverage Option (Reduced Paid-Up Option)**	Yes	Yes	Yes

(*Your Daily Benefit Maximum will be adjusted to include any inflation option increases, if applicable.)

The Lifetime Maximum Amount payable is: **

Plan A ($75)	Plan B ($100)	Plan C ($125)
1,825 X the "Long Term Care Facility" amount.	1,825 X the "Long Term Care Facility" amount.	1,825 X the "Long Term Care Facility" amount.

(**Your Lifetime Maximum Amount will be adjusted to include any inflation option increases, if applicable.)

Elimination Period is 90 consecutive days.

Cost

For information, see the discussion **"WHO PAYS FOR LONG TERM CARE INSURANCE?"** (page C-8).

In making any benefits determination under the Summary of Benefits, UNUM will have the discretionary authority both to determine an insured person's eligibility for benefits and to construe the terms of the Summary of Benefits.

INTRODUCTION TO THE UNUM PLAN

WHAT IS LONG TERM CARE INSURANCE?

Long term care insurance gives financial help if you need care as a result of a disability.

What is meant by disability and disabled?

Disability and disabled means you are unable to perform, without substantial assistance from another individual, at least three (3) activities of daily living; or you require substantial supervision by another individual to protect you from threats to health and safety due to severe cognitive impairment.

What are activities of daily living?

Activities of daily living (ADLs) are the activities you need to do to live independently. They are **BATHING, DRESSING, TOILETING, TRANSFERRING, CONTINENCE** and **EATING.**

- **BATHING** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- **DRESSING** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **TOILETING** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **TRANSFERRING** means moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- **CONTINENCE** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- **EATING** means feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

What is substantial assistance?

Substantial assistance means stand-by assistance by another person without which you would not be able to safely or completely perform the activity of daily living.

What is severe cognitive impairment?

Severe cognitive impairment means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests, in:

- short or long term memory;
- orientation to people, places or time; and
- deductive or abstract reasoning.

Such deterioration or loss requires substantial supervision by another individual for the purpose of protecting you from harming yourself or others. The loss can result from a disability, Alzheimer's disease or similar forms of demonstrable organic brain disease.

What is substantial supervision?

Substantial supervision means the presence of another individual for the purpose of protecting you from harming yourself or others.

WHO PAYS FOR LONG TERM CARE INSURANCE?

The coverage under this plan is contributory. This means you pay the full cost of your coverage under UNUM's long term care insurance.

How is the cost determined?

The premium rate to be paid over the duration of your initial coverage is based on your "insurance age" at the time of enrollment. Insurance age is your age as of the most recent Benefit Calculation Date (April 1st) or your date of hire, whichever is later. The Benefit Calculation Date for an initial enrolled employee is April 1, 1997. If you are a new employee, the Benefit Calculation Date is your date of employment. For all subsequent years, the Benefit Calculation Date is administratively set as April 1st, which is immediately prior to an Open Enrollment period. Any change in coverage is based on your age as of the most recent Benefit Calculation Date (April 1st).

The premium rate will not increase because you grow older or because of your use of the benefits. However, the premium rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies under this type of insurance.

How do you pay the premiums?

- If you are an active employee:

  Your Agency will deduct monthly premiums from your paycheck, which will be forwarded to the Sponsoring Organization. If you leave employment and are no longer eligible for coverage, you can continue the same coverage you had under this plan on a direct billing basis. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group long term care insurance ends?".

- If you are the active employee's spouse or the natural, adoptive or step-parents of an active employee, or the natural, adoptive or step-parents of the spouse of an active employee:

  UNUM will direct bill you or your authorized representative for the premiums. If the Sponsoring Organization ends coverage, you can continue the same coverage you had under this plan. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group long term care insurance ends?".

- If you are an employee on Leave Without Pay (LWOP):

  You must pay the monthly premium amount to the Flexible Benefits Program prior to the first of each coverage month, since premiums for coverage must be paid in advance of coverage. Coverage is extended on a month by month basis. Your insurance may be continued through the twelfth (12th) calendar month while you continue to be on leave without pay.

Is there a grace period?

The Sponsoring Organization will be allowed a grace period of 90 days after the premium due date for the remittance of each premium amount due. Insured persons who are direct billed will be allowed a grace period of 45 days after the premium due date for the remittance of each premium amount due. If such premium amount is not remitted within the grace period, coverage will terminate at the end of the grace period. However, if you voluntarily end your group long term care coverage, you may be eligible to continue a percentage of your Lifetime Maximum Amount. For more information see the discussion **"CAN A PERCENTAGE OF YOUR LIFETIME MAXIMUM AMOUNT BE CONTINUED IF PREMIUM PAYMENTS ARE STOPPED?".**

What if the Leave Without Pay (LWOP) employee does not remit premiums for coverage?

If the LWOP employee stops paying the required premium, coverage will end.

- If the LWOP employee returns to work within the same Plan Year in which (s)he previously participated in the Flexible Benefit Plan, the employee's department will collect missing premiums from the employee's salary, unless circumstances invoke a contractual limitation on coverage.
- If the LWOP employee is absent for less than six (6) months and returns to work in the Plan Year following the Plan Year in which (s)he previously participated in the Flexible Benefits Plan, the employee can reinstate coverage by paying the delinquent premiums. The employee who chooses not to reinstate coverage, will be subject to medical underwriting.
- If the LWOP employee is absent for six (6) or more months and returns to work in the Plan Year following the Plan Year in which (s)he previously participated in the Flexible Benefits Plan, coverage remains terminated. To re-enroll, the employee will be subject to medical underwriting.

What if the active employee's spouse, adoptive or step-parents of an active employee, or the natural, adoptive or step-parents of the spouse of an active employee does not remit premiums for coverage?

If coverage terminates because a premium is not paid by the end of the grace period, the covered family member may request to reinstate coverage at any time until twelve (12) months from the coverage termination date. To reinstate coverage, the following requirements must be met:

- Completion of an Application for Long Term Care Insurance; and
- Approval of the Application for Long Term Care Insurance by UNUM; and
- Payment of all unpaid premium(s).

If your Application for Long Term Care Insurance is approved, the reinstatement will take effect on the date your group coverage was terminated for non-payment of premiums.

Reinstatement WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

Can coverage be reinstated if coverage is terminated for non-payment of premium because of a disability?

If you become disabled and your coverage terminates because premium is not paid by the end of the grace period, you may request to reinstate your coverage at any time until five months from the coverage termination date.

In order to reinstate your coverage, the following requirements must be met:

- you must provide proof that your disability occurred prior to the coverage termination date; and
- you must pay all unpaid premium(s).

If you meet these requirements, we will reinstate your coverage on the coverage termination date.

The reinstated coverage WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

WILL PREMIUMS BE WAIVED WHILE YOU ARE RECEIVING A MONTHLY PAYMENT?

- **If you are receiving a "Long Term Care Facility" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - reside in a Long Term Care Facility.

  What is a Long Term Care Facility?

  A Long Term Care Facility is:

- an institution, or a distinctly separate part of a hospital, that is licensed or certified as a nursing home (if licensing or certification is required) or operates under the law as a nursing home to provide skilled, intermediate or custodial care and operates under state licensing laws and any other laws that apply; or

- any other institution that meets all of the following tests:

  - is operated as a health care facility under applicable state licensing laws and any other laws;

  - primarily provides nursing care under the orders of a physician;

  - provides patient care under the supervision of a registered nurse or a licensed practical nurse;

  - regularly provides room and board and continuous 24 hour a day nursing care of sick and injured persons;

  - maintains a daily medical record of each patient who must be under the care of a physician;

  - is authorized to administer medication to patients on the order of a physician; and

  - is not, other than incidentally:

    - a home for the mentally retarded, the mentally ill, the blind or the deaf, alcoholics or drug abusers, or

    - a hotel, a domiciliary care home or a residence; or

- a similar institution approved by UNUM.

What is a physician?

A physician is a person who is operating within the scope of his/her license, and is either:

- licensed to practice medicine and surgery and prescribe and administer drugs; or

- legally qualified as a medical practitioner and required to be recognized, under this plan for insurance purposes, according to the insurance laws of the governing jurisdiction.

UNUM will consider a person to be a physician only when the person is performing tasks that are within the limits of the person's medical license.

UNUM will not recognize:

- you, or

- your or your family member's spouse, daughter, son, parent, sister, brother, grandparent or grandchild

as physicians for claims that you make to UNUM for long term care insurance.

- **If you are receiving an "Assisted Living Facility" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - reside in an Assisted Living Facility.

  What is an Assisted Living Facility?

  An Assisted Living Facility is:

  - an institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage in providing ongoing care and services to a minimum of 10 inpatients in one location and operates under state licensing laws and any other laws that apply; or
  - any other institution that meets all of the following tests:
    - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a disability;
    - has an employee on duty at all times who is awake, trained and ready to provide care;
    - provides 3 meals a day, including special dietary requirements;
    - operates under applicable state licensing laws and any other laws that apply;
    - has formal arrangements for the services of a physician or nurse to furnish medical care in the event of an emergency;
    - is authorized to administer medication to patients on the order of a physician; and
    - is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers; or

    NOTE: These requirements are typically met by assisted living facilities that are either free standing facilities or part of a life care community. In general, they are not met by individual residences, boarding homes or independent living units.
  - a similar institution approved by UNUM.

- **If you are receiving a "Total Home Care" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to be disabled.

  What is Total Home Care?

  Total Home Care provides financial help in case you need care at home or another similar place due to a disability.

Total Home Care means:

- visits to your residence by a Home Health Care Provider to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services;
- Adult Day Care;
- Hospice Care; or
- care provided by an informal caregiver, such as your friends or relatives.

The treatment and services you receive must be provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner.

What is Adult Day Care?

Adult Day Care means care provided by a licensed Home Health Care Provider or an Adult Day Care Facility in a community-based group program offering health, social and related support services to impaired or disabled adults.

What is an Adult Day Care Facility?

Adult Day Care Facility is a facility that provides Adult Day Care and operates under state licensing laws and any other laws that apply; or meets the following tests:

- Operate a minimum of 5 days a week;
- Remain open for at least 6 hours a day;
- Not be an overnight facility;
- Maintain a written record of care on each patient;
- Include a plan of care and record of services provided;
- Have a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
- Have established procedures for obtaining appropriate aid in the event of a medical emergency; and
- Provide a range of physical and social support services to adults.

What is a Home Health Care Provider?

A Home Health Care Provider is:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care Services will be provided;
- certified as a home health care organization as defined under Medicare;
- any other organization that meets all of the following tests:
  - primarily provides skilled nursing care and other therapeutic services;
  - has standards, policies and rules established by a professional group which is associated with the organization;
  - includes at least one physician and one registered nurse;
  - maintains a written record of care on each patient; and
  - includes a plan of care and record of services provided; or
- a similar organization approved by UNUM.

What is hospice care?

Hospice care means a formal program of care for terminally ill patients whose life expectancy is less than 6 months, provided on an inpatient basis and directed by a physician in a hospice care facility that is licensed, certified or registered in accordance with state law.

What is a licensed health care practitioner?

A licensed health care practitioner means any physician, and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

WHO IS ELIGIBLE FOR THE PLAN?

Persons who are eligible for the plan are:

- Active employees of the Sponsoring Organization; and
- Family members of an active employee.

What is an active employee?

You are an active employee if you:

- are able to do the normal tasks of your job on a full-time basis for a full workday and are an employee of the State of Georgia, or of a State Agency. "Full-time" means someone who works at least 30 hours a week, on a continuing basis, and whose employment is expected to last at least nine months. Certain categories of employees are specifically excluded: student, seasonal, part-time, short-term, and sheltered workshop;

- are able to do such tasks at one of your employer's normal places of business or at a location to which you must travel to do your job;

- are a public-school teacher who is employed in a professionally certificated capacity, works half-time or more, and is not considered a "temporary" or "emergency" employee;

- are an employee of a local school system who holds a non-certificated position; who is eligible to participate in the Teachers Retirement System or its local equivalent; and who works at least 18 hours a week (or 60% of the time necessary to carry out the duties of the position if that is more than 18 hours); and

- an employee who is eligible to participate in the Public School Employees Retirement System, as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated, and who works at least 18 hours a week (or 60% of the time necessary to carry out the duties of the position).

What is a family member?

A family member is the:

- spouse of an active employee (you must be legally married to your spouse),

- the natural, adoptive or step-parents of an active employee, or

- the natural, adoptive or step-parents of a spouse of an active employee.

IF YOU ARE AN ACTIVE EMPLOYEE, WHEN ARE YOU ELIGIBLE TO ENROLL FOR LONG TERM CARE COVERAGE AND HOW DO YOU APPLY?

When may eligible employees enroll for coverage?

- Employees eligible to enroll for coverage to be effective July 1, 1997 may enroll for coverage during the initial Open Enrollment Period. Eligible employees who did not enroll during the initial Open Enrollment Period may also enroll for coverage, subject to medical underwriting, during any subsequent annual Open Enrollment Period as designated by the Employer.

- Employees eligible to enroll for coverage to be effective on or after August 1, 1997 (newly eligible employees) may enroll for coverage during an initial 15 day Open Enrollment period immediately following the date the employee is eligible for coverage. If a newly eligible employee chooses to not enroll during their initial Open Enrollment Period, they may also enroll for coverage as a current employee, subject to medical underwriting, during any subsequent annual Open Enrollment Period as designated by the Employer.

How do eligible employee apply for coverage?

- **During your initial Open Enrollment Period:**

  You can apply for coverage by completing your personalized Option Statement supplied by your Agency personnel/payroll office.

  If you do not already have your personalized Option Statement, you should contact your Agency personnel/payroll office immediately.

  After you complete your Option Statement, be sure you sign and date it. The Option Statement will not be valid unless you sign and date it.

  Return your completed Option Statement to your Agency benefits representative as instructed.

- **During the annual Open Enrollment Period:**

  You can apply for coverage by completing your personalized Option Statement and an Application for Long Term Care Insurance, which includes evidence of insurability. If you do not have a personalized Option Statement, contact your Agency personnel/payroll office immediately. If you do not have an Application for Long Term Care Insurance, contact UNUM at 1-800-227-4165.

  UNUM will pay any of the costs that it views as necessary to obtain any evidence of insurability that it requests.

  After you complete your Option Statement and Application for Long Term Care Insurance, be sure you sign and date them. The Option Statement and Application for Long Term Care Insurance will not be valid unless you sign and date them.

  Return your completed Option Statement to your Agency benefits representative as instructed. Send the completed Application for Long Term Care Insurance directly to UNUM to the address provided to you.

What is evidence of insurability?

If you do not enroll when first eligible (during the initial Open Enrollment Period or when first hired), you must complete the medical underwriting process as required by UNUM. The medical underwriting process includes the Application for Long Term Care Insurance and may also include other proof of your medical history such as test results, medical exams, physicians' statements, etc.

Unum may also request that an insurability assessment be performed. UNUM will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or reject an Application for Long Term Care Insurance.

UNUM has the right to contest the accuracy of any information completed throughout the medical underwriting process. If false or inaccurate statements submitted for the medical underwriting process result in approval of insurance, the insurance may be disallowed.

What is an insurability assessment?

An insurability assessment means a review done by UNUM or its designated representative to help in evaluating your cognitive and functional status. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by UNUM or its designated representative.

WHEN DOES COVERAGE BEGIN FOR AN ACTIVE EMPLOYEE?

- For employees who enroll during the initial Open Enrollment Period, coverage applied for will begin on July 1, 1997. New or additional coverage applied for during a subsequent Open Enrollment Period as designated by the Employer will be effective retroactively on July 1st of the Plan Year in which you are applying for coverage, following approval through medical underwriting by UNUM. You must meet the definition of an active employee.
- For employees hired on or after May 2, 1997, coverage applied for during your initial 15 day Open Enrollment Period will begin on the first of the month following employment for the full preceding calendar month. New or additional coverage applied for during a subsequent Open Enrollment Period as designated by the Employer will begin retroactively on July 1st of the Plan Year in which you are applying for coverage, following approval through medical underwriting by UNUM. You must meet the definition of an active employee.
- For employees eligible for coverage after July 1, 1997 (newly eligible employees), coverage applied for during your initial 15 day Open Enrollment Period will begin on the first of the month following employment for the full preceding calendar month. New or additional coverage applied for during a subsequent Open Enrollment Period as designated by the Employer will begin on July 1st of the Plan Year in which you are applying for coverage, following approval through medical underwriting by UNUM. You must meet the definition of an active employee.

What if you are an active employee and absent from work on the date your coverage would normally begin?

Coverage will not begin for you if you are absent from work because you are injured or sick.

The coverage will begin at 12:01 a.m. on the date you return to work as an active employee.

What if the Sponsoring Organization rehires you?

- If you are re-employed as an eligible employee during the same Plan Year in which you previously participated in the Flexible Benefit Plan, Long Term Care Insurance under the Plan will be reinstated. If you are re-employed after the first workday of a calendar month, coverage may become effective the first of the month following re-employment, provided a premium is remitted.

- If you are re-employed as an eligible employee after the Plan Year in which you previously participated in the Flexible Benefit Plan, you will be considered a newly eligible employee. You will be eligible to choose Long Term Care coverage without medical underwriting.

IF YOU ARE A FAMILY MEMBER, WHEN ARE YOU ELIGIBLE FOR LONG TERM CARE COVERAGE, WHEN AND HOW DO YOU APPLY?

When do you become eligible?

You will be eligible for coverage on the date the employee is eligible for coverage.

If you are eligible for coverage as an active employee, you are only eligible for coverage as an employee.

When can you apply for coverage?

You can apply for coverage any time after the date you become eligible for coverage.

How do you apply for coverage?

To apply for coverage, you must fill out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from UNUM at the address provided to you.

UNUM will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

Send the completed Benefit Elections Form and Application for Long Term Care Insurance directly to UNUM to the address provided to you.

What is evidence of insurability?

You must complete the medical underwriting process as required by UNUM. The medical underwriting process includes the Application for Long Term Care Insurance and may also include other proof of your medical history such as test results, medical exams, physicians' statements, etc.

UNUM may also request that an insurability assessment be performed. UNUM will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or reject an Application for Long Term Care insurance.

UNUM has the right to contest the accuracy of any information completed throughout the medical underwriting process. If false or inaccurate statements submitted for the medical underwriting process result in approval of insurance, the insurance benefit may be disallowed.

What is an insurability assessment?

An insurability assessment means a review done by UNUM or its designated representative to help in evaluating your cognitive and functional status. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by UNUM or its designated representative.

WHEN DOES COVERAGE BEGIN FOR A FAMILY MEMBER?

Coverage applied for will begin on the later of these dates:

- the plan effective date if UNUM approves your Application for Long Term Care Insurance on or before that date, or
- 12:01 a.m. on the first day of the month that occurs on or next follows the month in which UNUM approves your Application for Long Term Care Insurance.

CAN COVERAGE BE CHANGED FOR ACTIVE EMPLOYEES AND FAMILY MEMBERS?

If you are an active employee of the Sponsoring Organization, you can apply to change coverage during an annual Open Enrollment Period as designated by the Employer by filling out a new personalized Option Statement and an Application for Long Term Care Insurance.

If you are a family member, you can apply at any time to increase coverage by filling out a new Benefit Election Form and an Application for Long Term Care Insurance. If you are a family member, you can apply at any time to decrease coverage by filling out a new Benefit Election Form.

When will the changes take effect?

If you are an active employee of the Sponsoring Organization, the changes will take effect at 12:01 a.m. on the first day of the month that occurs on or next follows the month in which UNUM approves your Application for Long Term Care Insurance. The premium rate to be paid for any change in coverage is based on your insurance age. Insurance age is your age as of the most recent Benefit Calculation Date. The Benefit Calculation Date is administratively set as April 1st, which is immediately prior to an Open Enrollment period as designated by the Employer. Any change in coverage is based on your age as of the most recent Benefit Calculation Date (April 1st).

If you are a family member, the changes will take effect at 12:01 a.m. on the first day of the month that occurs on or next follows the month in which UNUM approves your Application for Long Term Care Insurance. The premium rate to be paid for any change in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the change in coverage.

Increases in the amount of insurance coverage will not take effect on the date they would normally take effect if:

- you are an active employee of the Sponsoring Organization and you are absent from work on that date because you are injured, sick, or on a leave of absence, or
- you are a family member and you are totally disabled on that date.

The increase or addition in insurance coverage will take effect at 12:01 a.m. on the date:

- you, an active employee of the Sponsoring Organization, return to work as an active employee, and
- you, a family member, no longer are totally disabled.

WHEN WILL GROUP COVERAGE THROUGH THE PLAN END FOR YOU?

When will coverage end?

Your coverage will end on the latest of these dates:

- the date the Summary of Benefits under the policy ends,
- the date you no longer are eligible,
- the date your total benefit payments equal your Lifetime Maximum Amount,
- the end of the period for which premiums were last remitted to UNUM for your coverage,
- the date you no longer are an active employee with the Sponsoring Organization, or
- the date you die.

In most cases, however, you may continue coverage after the coverage would normally end. For more information, see the discussion: "What happens when group long term care coverage ends?".

What if you are absent from work at STATE OF GEORGIA?

If you are absent from work for any reason, you will continue to be covered for group coverage if premiums are remitted.

If you are on Leave Without Pay, you must pay the monthly premium amount to the Flexible Benefits Program prior to the first of each coverage month. Your insurance may be continued through the twelfth (12th) calendar month while you are on leave without pay. After the twelfth (12th) calendar month of personal premium payments, your coverage will end. You may then elect portable coverage with UNUM. See the next section "What happens when group long term care coverage ends?"

What happens when group long term care coverage ends?

- **If the Sponsoring Organization or UNUM ends group long term care coverage**

  If you are an active employee, you or your authorized representative may elect portable coverage for you. This means that the same coverage you had under this plan can continue on a direct billing basis. Persons who are direct billed will automatically transfer to portable coverage.

  Any election for portable coverage must be made within 31 days of the date the group coverage would otherwise end. If so elected, you are a portable insured.

  Any premium that applies must be paid directly to UNUM by you for any portable coverage to be continued.

  Also, the premium rate schedule for portable coverage may change in the future, depending on the overall use of the benefits by all covered persons or changes in the benefit levels or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies.

  Once on portability, you can apply at any time to increase coverage by filling out a new Benefit Elections Form and Application for Long Term Care Insurance which includes evidence of insurability.

- **If your group long term care coverage ends because you chose to have premium payments stopped for your coverage:**

  You may not elect portable coverage. However, you may be eligible to continue a percentage of your Lifetime Maximum Amount. For more information see the discussion **"CAN A PERCENTAGE OF YOUR LIFETIME MAXIMUM AMOUNT BE CONTINUED IF PREMIUM PAYMENTS ARE STOPPED?".**

  CAN A PERCENTAGE OF YOUR MONTHLY BENEFIT MAXIMUM(S) AND LIFETIME MAXIMUM AMOUNT BE CONTINUED IF PREMIUM PAYMENTS ARE STOPPED?

  Yes.

  If you choose the paid-up coverage option at the time of enrollment and the required premiums are paid under this option for five consecutive years, a percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount will automatically continue without further premium payments.

If you choose the paid-up coverage option when you apply for additional coverage and the required premiums are paid under this option for five consecutive years, a percentage of your additional Monthly Benefit Maximum(s) and Lifetime Maximum Amount will automatically continue without further premium payments.

Calculations for the percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount that continue will be based on:

- your age on the date you choose the paid-up coverage option;
- how long premiums are continued to be paid under the paid-up coverage option beyond five consecutive years; and
- your Monthly Benefit Maximum(s) and Lifetime Maximum Amount inforce at the end of the period for which premiums were last remitted to Unum for your coverage.

In no event will the percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount:

- include any inflation option adjustments, if applicable, after the end of the period for which premiums were last remitted to Unum for your coverage; or
- exceed 100% of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount inforce at the end of the period for which premiums were last remitted to Unum for your coverage.

You can determine the percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount that will continue by using the following Paid-up Coverage Table:

PAID-UP COVERAGE TABLE

Number of Consecutive Years Premiums Have Been Paid Under The Paid-up Coverage Option	Percentage Of Your Monthly Benefit Maximum(s) and Lifetime Maximum Amount That Would Continue				
	Under Age 40	Age 40 to 49	Age 50 to 59	Age 60 to 69	Age 70 & Over
5 & Under	0.00%	0.00%	0.00%	0.00%	0.00%
6	20.00%	22.00%	24.00%	28.00%	32.00%
7	21.25%	23.50%	26.00%	30.50%	35.00%
8	22.50%	25.00%	28.00%	33.00%	38.00%
9	23.75%	26.50%	30.00%	35.50%	41.00%
10	25.00%	28.00%	32.00%	38.00%	44.00%
11	26.25%	29.50%	34.00%	40.50%	47.00%
12	27.50%	31.00%	36.00%	43.00%	50.00%
13	28.75%	32.50%	38.00%	45.50%	53.00%
14	30.00%	34.00%	40.00%	48.00%	56.00%
15	31.25%	35.50%	42.00%	50.50%	59.00%
16	32.50%	37.00%	44.00%	53.00%	62.00%
17	33.75%	38.50%	46.00%	55.50%	65.00%
18	35.00%	40.00%	48.00%	58.00%	68.00%
19	36.25%	41.50%	50.00%	60.50%	71.00%
20	37.50%	43.00%	52.00%	63.00%	74.00%
21	38.75%	44.50%	54.00%	65.50%	77.00%
22	40.00%	46.00%	56.00%	68.00%	80.00%
23	41.25%	47.50%	58.00%	70.50%	83.00%
24	42.50%	49.00%	60.00%	73.00%	86.00%
25	43.75%	50.50%	62.00%	75.50%	89.00%
26	45.00%	52.00%	64.00%	78.00%	92.00%
27	46.25%	53.50%	66.00%	80.50%	95.00%
28	47.50%	55.00%	68.00%	83.00%	98.00%
29	48.75%	56.50%	70.00%	85.50%	100.00%
30	50.00%	58.00%	72.00%	88.00%	
31	51.25%	59.50%	74.00%	90.50%	
32	52.50%	61.00%	76.00%	93.00%	
33	53.75%	62.50%	78.00%	95.50%	
34	55.00%	64.00%	80.00%	98.00%	
35	56.25%	65.50%	82.00%	100.00%	
36	57.50%	67.00%	84.00%		
37	58.75%	68.50%	86.00%		
38	60.00%	70.00%	88.00%		
39	61.25%	71.50%	90.00%		
40	62.50%	73.00%	92.00%		
41	63.75%	74.50%	94.00%		
42	65.00%	76.00%	96.00%		
43	66.25%	77.50%	98.00%		
44	67.50%	79.00%	100.00%		
45	68.75%	80.50%			
46	70.00%	82.00%			
47	71.25%	83.50%			

48	72.50%	85.00%
49	73.75%	86.50%
50	75.00%	88.00%
51	76.25%	89.50%
52	77.50%	91.00%
53	78.75%	92.50%
54	80.00%	94.00%
55	81.25%	95.50%
56	82.50%	97.00%
57	83.75%	98.50%
58	85.00%	100.00%
59	86.25%	
60	87.50%	
61	88.75%	
62	90.00%	
63	91.25%	
64	92.50%	
65	93.75%	
66	95.00%	
67	96.25%	
68	97.50%	
69	98.75%	
70	100.00%	

FOR EXAMPLE: The percentage of your Monthly Benefit Maximum(s) and Lifetime Maximum Amount that would continue based on your insurance age being 25 on the date you chose the paid-up coverage option and continuing for 10 consecutive years would be 25.00%.

LONG TERM CARE INSURANCE

WHAT ARE LONG TERM CARE BENEFITS?

A long term care benefit will be paid to you if you become disabled according to the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS. The amount of the monthly payment will depend on:

- the long term care plan of coverage you choose;
- any options you choose, if available; and
- the place of residence used for long term care.

What is the Lifetime Maximum Amount you can receive under the Summary of Benefits?

The Lifetime Maximum Amount is the maximum UNUM will pay you over the life of your coverage for all long term care benefits. Your Lifetime Maximum Amount depends on the benefit level you have chosen.

The Lifetime Maximum Amount under the Summary of Benefits for this certificate is shown in the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS.

Your Lifetime Maximum Amount will be adjusted to include any inflation option increases, if applicable.

HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?

You will qualify to receive monthly payments from UNUM after:

- you become disabled;
- you are receiving services in a Long Term Care Facility or Assisted Living Facility; or you are receiving Total Home Care;
- you have satisfied your Elimination Period; and
- a physician has certified that you are unable to perform (without substantial assistance from another individual) three or more ADLs for a period of at least 90 consecutive days, or that you require substantial supervision by another individual to protect you and others from threats to health or safety due to severe cognitive impairment. You will be required to submit a physician certification every 12 months.

The treatment and services you receive for your disability must be provided pursuant to a written plan of care developed by a licensed health care practitioner.

WHEN WILL YOU RECEIVE MONTHLY PAYMENTS FOR LONG TERM CARE?

You will receive monthly payments from UNUM once you qualify. For information on how to qualify to receive long term care monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?".**

What is the Elimination Period?

The Elimination Period is ninety (90) consecutive days during which you must continue to qualify to receive long term care monthly payments before benefits can become payable. For information on how to qualify to receive long term care monthly payments see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?".**

The Elimination Period under the Summary of Benefits for this certificate is shown in the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS.

HOW MUCH WILL UNUM PAY IF YOU BECOME DISABLED?

If you become disabled and qualify to receive monthly payments, UNUM will send the payment to you each month. The amount of the monthly payment will be based on the plan(s) and option(s), if available, that you have chosen from the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS. See your CONFIRMATION FORM to determine the amount UNUM will pay you each month.

- **If you qualify for a "Long Term Care Facility" payment for a period that is less than one month,** UNUM will pay 1/30th of your "Long Term Care Facility" Daily Benefit Maximum for each day that you:
  - are disabled; and
  - reside in a Long Term Care Facility.

- **If you qualify for an "Assisted Living Facility" payment for a period that is less than one month,** UNUM will pay 1/30th of your "Assisted Living Facility" Daily Benefit Maximum for each day that you:

  - are disabled; and

  - reside in an Assisted Living Facility.

- **If you are qualify for a "Total Home Care" payment for a period that is less than one month,** UNUM will pay 1/30th of your "Total Home Care" Daily Benefit Maximum for each day that you are disabled.

For information on how to qualify to receive monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?".**

WILL UNUM PAY A FACILITY BENEFIT IF YOU ARE HOSPITALIZED?

If you are receiving a Long Term Care Facility or Assisted Living Facility monthly benefit and your stay in the Facility is interrupted because you are hospitalized, we will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the Facility.

If your stay is interrupted because you are hospitalized while you are completing your Elimination Period, such days will be used to help satisfy this period.

Bed Reservation days will be limited to 15 days per calender year.

HOW LONG WILL UNUM CONTINUE TO PAY YOU FOR LONG TERM CARE BENEFITS?

UNUM will continue monthly payments to you for long term care benefits until the earliest of the following dates:

- the expiration of your physician certification,
- the date you no longer are disabled,
- the date you no longer qualify to receive a monthly payment under the long term care plan of coverage you chose,
- the date your total benefit payments equal the Lifetime Maximum Amount, or
- the date you die.

CAN LONG TERM CARE BENEFITS BE INCREASED TO PROTECT AGAINST INCREASING COST?

Yes.

- **If you choose the Inflation Protection Option at the time of enrollment,** your initial amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your amount of coverage in effect on the last day of the previous calendar year.

If you decline the inflation option at the time of enrollment, you cannot choose it at a later date for that amount of coverage chosen at the time of enrollment.

- **If you choose the Inflation Protection Option when you apply for additional coverage,** your additional amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your additional amount of coverage in effect on the last day of the previous calendar year.

  If you decline the inflation option at the time you apply for additional coverage, you cannot choose it at a later date for that additional amount of coverage.

- **FOR EXAMPLE:** A monthly benefit amount of $1,000 will be increased by 5% of $1,000 for an amount of coverage equal to $1,050 for the next calendar year; 5% of $1,050 for an amount of coverage equal to $1,103 for the following calendar year; and so on.

As long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you are disabled.

No inflation increases will be made after the end of the period for which premiums were last remitted to UNUM for your coverage.

CAN YOU RECEIVE ANY PAYMENTS WHILE YOU ARE RECEIVING RESPITE CARE IF UNUM IS NOT YET MAKING LONG TERM CARE MONTHLY PAYMENTS?

Yes. If you qualify for a Total Home Care monthly benefit but are not yet receiving monthly payments because you:

- have not yet completed the Elimination Period; or
- have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount

UNUM will make payments to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your Total Home Care Monthly Benefit Maximum for each day that you receive respite care. Payments made to you for respite care will reduce your Lifetime Maximum Amount under the Summary of Benefits.

You **do not** have to complete the Elimination Period for respite care payments to become payable.

Premiums are **not** waived while you are receiving a payment for respite care.

What is respite care?

Respite care means care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities.

Respite care may be provided to you by:

- a formal caregiver, such as a Home Health Care Provider, an Adult Day Care Facility, a registered nurse, a licensed practical nurse, etc., or
- an informal caregiver such as your friends or relatives.

WHAT IF YOU BECOME DISABLED AGAIN AFTER RECEIVING LONG TERM CARE PAYMENTS FROM UNUM?

If you become disabled again after UNUM stopped making long term care payments to you for the previous loss, you **do not** have to satisfy a new Elimination Period. UNUM will pay long term care benefits to you until the earliest of the dates listed in the discussion **"HOW LONG WILL UNUM CONTINUE TO PAY YOU FOR LONG TERM CARE BENEFITS?".**

WHAT IF YOU DIE BEFORE RECEIVING ANY MONTHLY PAYMENTS FOR LONG TERM CARE?

If you die before benefits become payable under this plan, UNUM will make a payment to your eligible survivor when proof is received that:

- you were under age 75 on the date of your death;
- premium payments for your coverage were continued until the date of your death; and
- you had never received any payments from UNUM for long term care benefits, including any payments for Respite Care, under this plan.

The amount of the payment to be paid to your eligible survivor will equal a percentage of the premium payments remitted to UNUM for your coverage up to the date of your death.

The percentage of your premium payments that will be paid to your eligible survivor will be based on the following Table:

Age At Date of Death	Percentage of Premium Remitted
Less than 65	100%
65	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75	0%

Who is your eligible survivor?

For purposes of this benefit, your eligible survivor will be determined in the following order:

- your spouse, if living (you must be legally married to your spouse);
- your children; or
- your estate.

WHAT IS NOT COVERED FOR LONG TERM CARE?

UNUM will not make long term care payments to you for:

- disabilities caused by war (whether declared or not) or any act of war,
- disabilities caused by attempted suicide (while sane or insane) or self-destruction,
- disabilities caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,

- disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- any days over fifteen days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- disabilities caused by alcoholism,
- disabilities caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- disabilities caused by psychological or psychiatric conditions which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia, or
  - manic depressive disorders

  whether treated by drugs, counseling or other forms of therapy.

  However, UNUM **will** make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.

CAN UNUM HELP YOU REGAIN THE ABILITY TO INDEPENDENTLY ENGAGE IN THE ACTIVITIES OF DAILY LIVING OR COGNITIVE FUNCTION?

While you continue to have a disability, UNUM may suggest alternate care designed to help you regain the ability to independently engage in the activities of daily living or regain cognitive function. Examples of alternate care may include, but are not limited to:

- a rehabilitation program;
- home modifications for wheelchair access; and
- certain types of medical equipment or hardware purchases.

The terms of alternate care and the actual expenses that UNUM will pay will be subject to written mutual agreement between UNUM and you or your authorized representative. When appropriate, UNUM may pay reasonable expenses which are not otherwise payable by Medicare, Medicaid or other insurance.

If, for any reason, you do not wish to accept alternate care, your benefits will continue according to the provisions of the Summary of Benefits.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS INSURANCE BE USED?

UNUM considers any statements you make for insurance in any signed application(s) for initial coverage and/or any subsequent changes in coverage to be complete and true to the best of your knowledge and belief. If any of these statements are not complete and/or not true at the time they are made, UNUM can:

- reduce or deny any claim, or
- terminate insurance from the original effective date.

UNUM must use only the statements made in the signed application(s) as a basis for doing this.

UNUM can take these actions only in the first 2 years your initial coverage or changes in coverage is in force.

CAN UNUM RESCIND COVERAGE OR DENY A VALID LONG TERM CARE CLAIM FOR MISREPRESENTATION?

For a certificate that has been in force for less than six (6) months, UNUM may rescind coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

For a certificate that has been in force for at least six (6) months but less than two (2) years, UNUM may rescind coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After a certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone; such a certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to his/her health.

CAN THE SPONSORING ORGANIZATION ACT AS UNUM'S AGENT?

For all purposes of the Summary of Benefits, the Sponsoring Organization acts on its own behalf or as the employee's agent. Under no circumstances will the Sponsoring Organization be deemed UNUM's agent.

IS THE SUMMARY OF BENEFITS GUARANTEED RENEWABLE?

The Summary of Benefits is guaranteed renewable on each Anniversary Date.

What does UNUM mean by Guaranteed Renewable?

Guaranteed renewable means that the Summary of Benefits will continue in force subject to the following conditions:

- the Sponsoring Organization gives UNUM relevent information that UNUM requires within a reasonable time that is agreed upon by UNUM and the Sponsoring Organization.
- the Sponsoring Organization performs all of its obligations that relate to the Summary of Benefits, and
- the Sponsoring Organization continues to remit all premiums due within the grace period.

CLAIM INFORMATION

WHEN DO YOU FILE A CLAIM FOR LONG TERM CARE PAYMENTS?

Written notice of a claim must be given within 30 days after the date that your disability began or as soon as it is reasonably possible to do so.

If you do not have a Long Term Care Notice of Claim Form, you can get one from your UNUM representative by calling 1-800-331-1538, or you can notify UNUM in writing that you want to make a claim. If you do not receive the form from UNUM within 15 days after writing, send UNUM proof of the claim without the form.

You must send UNUM proof of claim for long term care payments no later than 90 days after the end of the first monthly period for which you are eligible to receive long term care payments from UNUM. If you cannot send UNUM proof within this 90-day period, you must send UNUM proof as soon as it is reasonably possible to do so, but in no event more than one year after the time proof is otherwise required.

The proof of your claim must include:

- the date your disability occurred;
- the cause of your disability;
- the extent of your disability;
- certification by a physician that you are unable to perform (without substantial assistance from another individual) three or more ADLs for at least 90 days, or that you require substantial supervision by another individual to protect yourself and others from threats to health or safety due to severe cognitive impairment;
- your written plan of care developed by a licensed health care practitioner;
- such other proof as we may deem necessary.

You must give UNUM proof of continued disability at intervals requested by us. Such proof must be given within 30 days of our request. If it is not possible for you to give proof of continued disability within this 30-day period, it must be given as soon as reasonably possible. However, proof of continued disability must be given no later than one year after the time proof is otherwise required.

HOW DO YOU FILE A CLAIM FOR LONG TERM CARE PAYMENTS?

You or your authorized representative must fill out, detach and mail the Notice of Claim postcard to UNUM. This postcard is provided as an attachment to the Long Term Care Claim Form.

You or your authorized representative must also fill out the Long Term Care Claim Form and send it to UNUM. If you have enough information to fully complete and send the Long Term Care Claim Form, you do not need to send the Notice of Claim postcard separately.

Once UNUM receives the Notice of Claim postcard and/or the Long Term Care Claim Form, a Claims Representative will contact you or your authorized representative to review the information on the form(s) and answer any questions you may have.

As part of proof of claim, UNUM may request that a claims assessment be performed.

UNUM may also send your attending physician(s) a Long Term Care Attending Physician's Initial Statement Form to fill out and send to UNUM. In some cases, UNUM may require additional Attending Physician's Progress Statements if you continue to be disabled.

After you have filed a claim, UNUM may also require you to be examined by a physician or other medical practitioner of UNUM's choice. UNUM will pay for the examination. UNUM can require an examination as often as it is reasonable to do so.

UNUM may require you or your authorized representative to give it authorization to obtain additional medical and nonmedical information as part of the proof of claim.

What is a claims assessment?

A claims assessment means a review done by UNUM or its designated representative to help in evaluating the status of your disability. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by UNUM or its designated representative.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or an authorized representative may not sue on your claim before 60 days after proof of loss has been given to UNUM. You or an authorized representative may not sue after 3 years from the time proof of loss is required.

WHEN WILL UNUM BEGIN TO SEND YOU LONG TERM CARE PAYMENTS?

When UNUM receives acceptable proof of your claim for long term care payments, UNUM will begin to send you long term care payments if you have qualified. For more information, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?"**.

UNUM will send you a lump sum payment to cover the period of time between the day you became eligible for benefit payments and the day you were approved for benefit payments. UNUM will then send you a payment each month during any remaining period you are disabled for which you are eligible to receive long term care payments. For information about how long UNUM will continue to send long term care payments, see the discussion **"HOW LONG WILL UNUM CONTINUE TO PAY FOR LONG TERM CARE BENEFITS?"**.

HOW DOES UNUM'S RIGHT OF RECOVERY AFFECT YOUR CLAIM?

UNUM has the right to recover any overpayments made because of any error UNUM makes in processing your claim.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Summary of Benefits, including your Certificate of of Coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, your Certificate of Coverage and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. Unum must receive a completed claim form. The form must be completed by you or your authorized representative. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIM PROCEDURES

The time periods provided in this section will apply to claims procedures under the Summary of Benefits unless a shorter time period is stated in the Summary of Benefits.

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

1. the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and

3. a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

The time period provided in this section for submitting an appeal will apply unless a longer time period for submitting an appeal is stated in the Summary of Benefits.

The time period provided in this section for making a final appeal decision will apply unless a shorter time period for making a final appeal decision is stated in the Summary of Benefits.

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

1. submit a request for review, in writing, to Unum;

2. upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

3. submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notices of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Sponsoring Organization or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials. This does not apply if the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, (for example, if the courts find your claims frivolous) the court may order you to pay these costs and fees.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligiblity for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in the evaluating those decisions.